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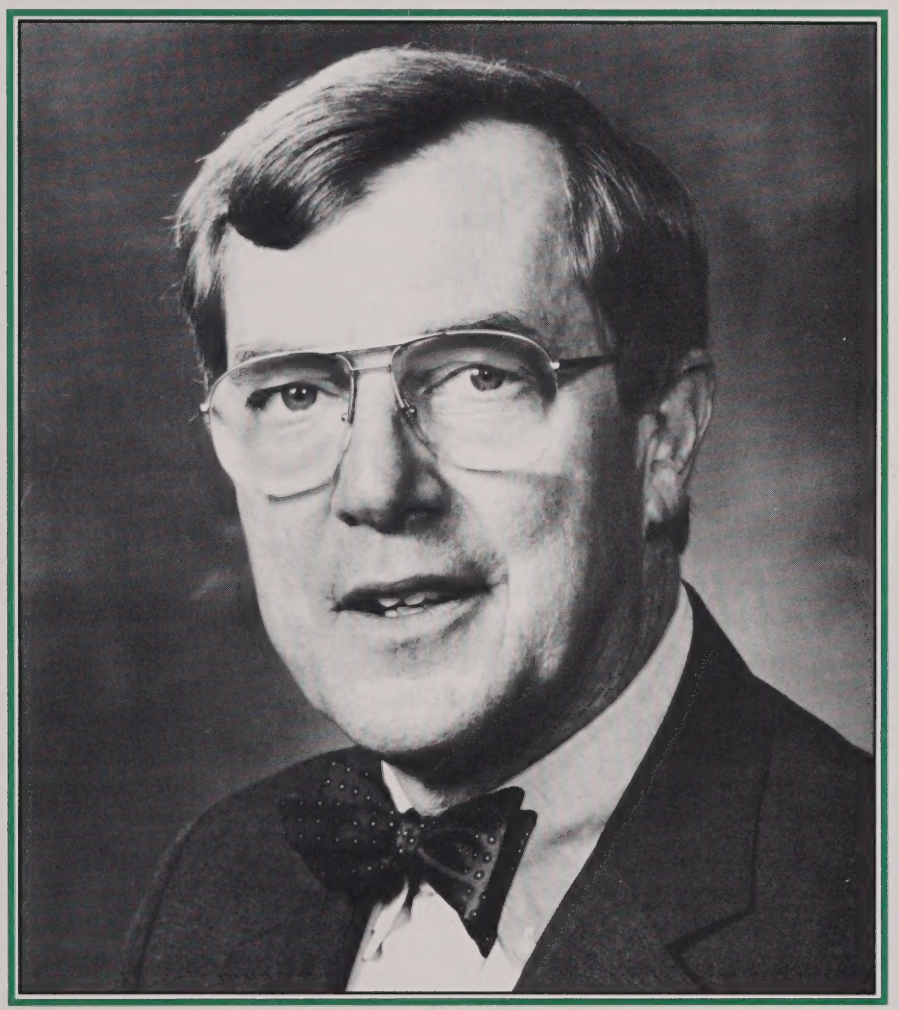

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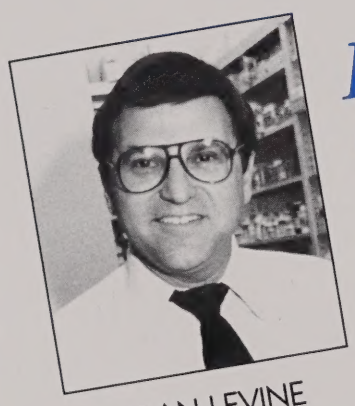

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THE
Hampden Hippocrat
SPRING 1996

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HAMPDEN DISTRICT MEDICAL SOCIETY 1995-1996 SEASON

ANNUAL MEETING

PLACE: **CARRIAGE HOUSE**
Old Storrowton Tavern
West Springfield, MA

DATE: Tuesday, April 23, 1996

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m. SPOUSES ARE WELCOME!

SPEAKER: Honorable Brian P. Lees
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NOTE: If you must cancel your dinner reservation, please call the HDMS office before noon on April 23rd. If the cancellation is not made, you will be BILLED for your dinner.

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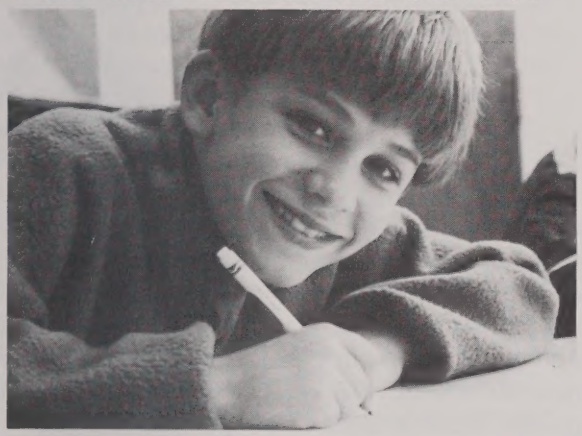

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From The Editor

My editorial neck is on the block. In the name of controversy I have used my editorial license to pen a couple of pieces in a style perhaps less staid than is usual for the Hippocrat. Losing my job as editor is, however, not the most awful outcome. Failing to get some of you to respond would be. Whether a letter to the editor or another article, interchange from members on important issues is what we would like to occur.

Although not one of the pieces mentioned above, the article on Dr. Johnson's address raises questions. It appears that he made a good case for the AMA's support of the Republican scheme to revamp Medicare. The problem is that while the plan is nominally related to the worthy goals of improving productivity and self reliance, the numbers seem to have come from the need to save enough to pay for a predetermined tax cut. The people who will lose out on both the tax cut and the Medicare changes are generally the same, i.e., those on the lower end of the economic scale. The plan also reminds me more of the theme that the business of America is business, than the belief that the purpose of America is democracy, freedom, and justice under law.

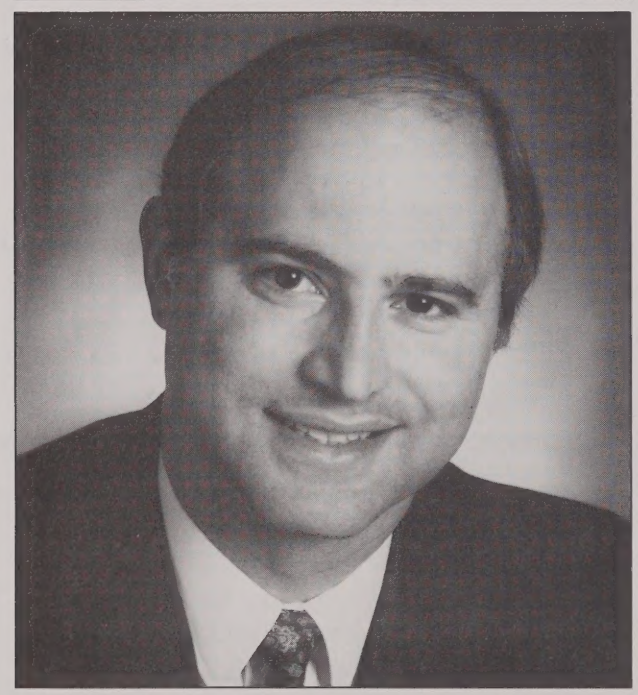
Dennis S. Gordan, M.D.
Editor

Correction

The Hippocrat regrets that Russell Stewart, M.D., author of "A Hampden County Address!?" in the winter issue, was incorrectly identified as Russell Steward, M.D. The editors apologize.

Gas Wars

Every morning on my way to work, I pass the intersection of Allen and Cooley Streets. It is an interesting four-way intersection with a gas station on each of the four corners; by itself, not so amazing. However, each day I notice the



John Papale, M.D., President

prices of the gasoline prominently displayed, and two observations always come to mind: the gasoline prices of the four stations are always nearly identical (within one or two cents of each other) and they are always several cents less than the same brands in other areas. I have often thought of asking the proprietors why this is so, but I suspect the answer will be the same as that given to me by relatives in the same business: We need to keep the price low to attract customers, otherwise one of my competitors will attract all of the business. Would they switch for two or three cents a gallon? Yes, I've done that experiment. What about service and loyalty? It doesn't matter anymore, the number one concern is price. To a large degree, they are right. There is little service at a gas station (notice we do not even call them service stations anymore), and it is very easy for the customer to compare the product from one merchant to the other. It is the same product. Why shouldn't the consumer pick by price?

Medicine is a profession that some insurers would like to look upon as a commodity similar to gasoline. There may be many providers of this service, but even though the product may not be exactly the same, it is similar. Therefore, why not go with the cheapest one? While reducing the cost of health care is an admirable goal, one must ask who will reap the benefits? In our gasoline model, the consumer directly benefits from any reduction in price; since health care now has an intermediary (i.e. insurance companies), the consumers, our patients, benefit only indirectly. The direct savings are accrued immediately by the insurance companies who currently are the true buyers of most services in our current market.

While the true consumers of our services have changed, the method of reimbursement has undergone an even more dramatic transformation. Most of us still remember fee-for-service; indeed some of us may still earn a living this way! Staff-model closed panel HMO's were next to enter the Pioneer Valley (e.g. Medical West and Kaiser) and these plans employed salaried physicians who worked strictly for the HMO.

Next, IPA's and PPO's (e.g. Health New England and Pioneer) entered the market. These plans monitored physician utilization and a small portion of the physician's income was subject to a group (not an individual) withhold. A new form of reimbursement has now entered the Pioneer Valley–the capitated extreme risk contract*–which puts individual physicians or groups of physicians at risk (usually by specialty), and directly rewards them for limiting expenditures (e.g. Secure Horizons). Some HMO's are now putting physician services up to bid in these risk contracts, allowing insurance companies the opportunity to pick the lowest bid amongst competing groups of physicians.

Price wars in medicine are a relatively new phenomenon. For years, the major battles have occurred amongst insurance companies, with physicians being somewhat insulated from directly competing on the basis of price. Western Massachusetts had been isolated from the price wars of large metropolitan areas, but our comfort zone has now also been affected. Extreme risk contracts are now available in Western Massachusetts which put physicians in a potential conflict of interest. These plans directly link physician earnings with the ability to tightly control the costs of patient care. This has the benefit of potentially reducing total health care costs to a bare minimum, since the person holding the purse strings is ostensibly the person who knows best how to spend the money (e.g. a highly trained physician). Some of the money the physician saves goes into physician earnings, and such a scenario potentially puts the financial interest of the physician in conflict with the care of the patient. While this conflict has occurred to some degree in many arrangements, the direct connection has never been so bold or obvious. An excellent editorial discussing some of the issues involved in these contracts was published in the December 21, 1995 issue of the *New England Journal of Medicine*.* It should be required reading for all of us who plan on practicing into the next century.

We must be careful to not sell ourselves short or price our services in such a fashion that we constantly waiver about ordering tests, seeing emergency office patients or admitting patients to the hospital. We must not be the dupes of companies who are more than willing to use our individual vulnerability as their tool to increased profits. We must not let the care of our patients suffer in order to increase profits. We are entering a brave new world involving a fundamental paradigm shift. We used to ask "How much can I do for my patient to provide the best care possible?" We may now be asking "How little can be done to still provide adequate health care?" Fee-for-service medicine attempted to answer the former question. That approach encouraged the risk of increasing costs. Managed care plans began to ask the latter. Extreme risk capitated contracts have the potential of pushing the answer to the limit and beyond. As individuals we are subject to the pressures of HMO's and we may make judgements to protect our patient base that ultimately are not in our best interest.

We must remember the number one rule I learned when studying game theory in high school. Yes, there is an entire literature on this subject! The authors often used the gas wars as a prime example of how not to play the game. The number one rule was that all of the station owners would benefit more from cooperation rather than competition. We cannot fix prices, but we should be sharing factual information about utilization and costs so that none of us gets caught in contractual arrangements we may someday regret. We can legally form larger associations to decrease risk and share costs within our own specialty and amongst different specialties. Cooperation, not competition, will not only decrease our collective stress but will also ultimately best serve our patients. ■

*Woolhandler, S. and Himmelstein, D. Extreme Risk–The New Corporate Proposition for Physicians, N. Eng. J. Med. 1995; 333: 1706-1708

1995 Interim Meeting Of The House Of Delegates

by Alan M. Harvey, M.D., MBA
Alternate Delegate to AMA, Massachusetts

Introduction

- The AMA House of Delegates met in Washington, D.C., December 3-6, 1995
- The House considered 170 resolutions and 95 Board and Council reports on an array of topics affecting medical practice and the public health of the American people.
- There are 432 voting delegates, representing every state and virtually every national medical specialty society.

Study Of The Federation

The Board of Trustees transmitted a report of the Study of the Federation project containing 34 recommendations to improve the effectiveness of the whole Federation on behalf of physicians. This project was initiated to help organized medicine adapt to a changing environment that is driving significant change in all medical societies as well as in the practice of medicine. The 34 recommendations in the report can be divided into two categories.

1. What can be done to make the Federation more functionally effective? How can we reduce duplication of effort, and thus cost? How can we achieve more coordination and, thereby, have more impact in our advocacy efforts? How can we offer to members products and services that are the "best value?"
2. What needs to be done to the structure of the Federation in order to enable and facilitate the functional improvements described above? How can all components of organized medicine and all facets of physicians' professional lives be reflected in the Federation, so that the Federation is empowered and credible enough to speak and act on behalf of the whole profession?

The Reference Committee and the House modified a number of the proposals and took the following actions:

1. The Federation of Medicine should be structured in a way that enables each medical association to retain its individual identity and activities, but which functions more like a total enterprise. The AMA should become the framework within which a new Federation of medicine is established. (adopted)
2. The restructured Federation of organized medicine should build on the basic components of the existing Federation: local medical societies/counties, state medical societies, specialty societies and the national umbrella organization (The AMA). Additional components may need to be included. (adopted)
3. Individual physician membership should remain the predominant form for membership in all components of the Federation. (adopted)
4. The primary objectives of the new Federation should be: (1) an increase in value of membership; and (2) unity of voice and action of all Federation components.(adopted)
5. Physicians should be encouraged to join organized medicine at all levels of the restructured Federation. There should be initiatives to encourage maximal collaboration in membership development efforts among components of the Federation. (adopted)
6. Federation participants must recognize that achieving real unity of voice and action and achieving true enhancement of the value of membership will require significant streamlining of roles throughout the Federation to reduce duplication (i.e., cost and dues) and create synergy. (adopted)

7. The roles of organizations serving physicians should be clarified and positioned to take full advantage of the strategic advantages enjoyed by each kind of organization. The Federation of organized medicine will be a catalyst and a forum for pursuing collaborative efforts to enhance the value of membership throughout the Federation. This effort will be the highest priority in the implementation process for creating the new Federation. (adopted)
8. The AMA House of Delegates should be composed of individuals representing organizations that reflect the major dimensions of a physician's life. (adopted)
9. The Federation House of Delegates should strive to be as inclusive as possible of physician organizations that have a stake in, and a contribution to make to, the goals of the Federation. (adopted)
10. State societies should be represented by one delegate for every 1000 AMA members or portion thereof.(adopted)
11. State societies should continue to count AMA direct members from that state for purposes of determining delegation size. (adopted)
12. specialty societies should continue to have representation in the AMA House of Delegates with a delegate allocation formula to be developed for the consideration of the AMA House of Delegates at its 1996 Annual Meeting. (adopted)
13. The current criteria for specialty society eligibility will continue to apply. (adopted)
14. State societies should continue to get a "bonus delegate" for being unified. Specialty societies that are unified should also get a "bonus delegate." (adopted)
15. Consistent with the idea that "voting" is not the only way to participate in an organization, mechanisms should be established through which organizations or groups of physicians with particular interests can meaningfully participate in the Federation without having a vote in the House of Delegates. The AMA Council in Long Range Planning should be asked to identify such mechanisms.(adopted)
16. Consistent with Section 2.73 of the AMA Bylaws, the Speaker of the House shall establish a special committee of the House to study ways to enhance the election process

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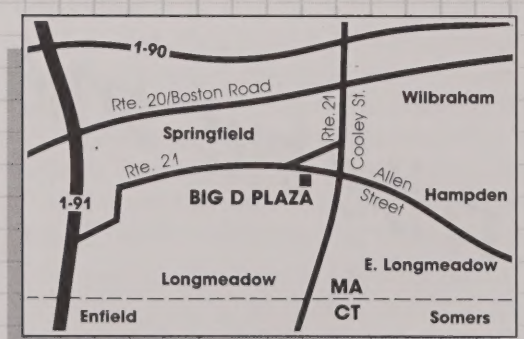

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Delegate's Report

Continued from previous page

for positions on the AMA Board of Trustees and to study the size, composition, and terms of service of the AMA Board to enable it to function in the context of the new Federation of Medicine. At a minimum, a progress report on the work of this committee should be presented to the AMA House at its 1996 Annual Meeting. The final report of this committee shall be presented to the House no later than the 1996 Interim Meeting. (adopted)

17. The AMA Councils, and other governance elements should be analyzed by the council on Long Range Planning to determine if similar efforts to reflect change should be made in each case. (adopted)
18. To establish a new, effective Federation of Medicine, a mechanism will be needed for the purposes of :

    a. Clarifying roles and achieving active coordination of efforts:

    i) developing a process for helping to coordinate the response of medical associations to key issues,

    ii) enhancing communications among medical associations and between medical associations and physicians,

    b. Establishing a process for pursuing collaborative efforts among federation members:

    i) identifying opportunities, including joint ventures, for medical associations to work together,

    ii) promoting information sharing and compatible database development among medical associations.(adopted)
19. The current Project Team of the Study of the Federation shall provide a report at the 1996 AMA Annual Meeting that clarifies and provides more detail regarding specialty society representation and representation by major dimensions of a physician's professional life. Further, the Project Team should provide more specific details regarding how the new Federation should be implemented, including transition steps. In pursuing its work between now and the 1996 Annual Meeting, the Project Team should solicit broad input from components of the Federation to determine and assess their attitudes, desires, and intent regarding the principles of the restructured Federation. The report of the Project Team shall be made available to all Federation components well in advance of the 1996 Annual Meeting so

that everyone will have the opportunity to review it thoroughly and be able to act on it at the 1996 Annual Meeting. (adopted)

In addition, some proposals for revising the representational structure within the House of Delegates were referred to the Board of Trustees for a report back at the 1996 Annual Meeting.

Mandatory Point of Service

The Council on Medical Service submitted a report describing the distinction between optional and mandatory point-of-service (POS) features and providing a comprehensive discussion of the impact of a mandatory POS feature on long-standing AMA policy on pluralism, on the cost of providing medical services, and in the current political and legislative climate. The report responded to three resolutions submitted at the previous meeting. An additional resolution was submitted calling for all managed care plans to required to have a POS feature automatically built into them that allows patient access to providers outside the plan at any time for a non-prohibitive additional co-payment for medically necessary services.

After extensive debate, the House voted to reaffirm current policy and added a new recommendation:

1. Reaffirm policy which states that all health plans or sponsors of such plans that restrict a patient's choice of physicians or hospitals be required to offer, at the time of enrollment and at least for a continuous one-month period annually thereafter, an optional "point-of-service-type" feature so that patients who choose such plans may elect to self-refer to physicians outside of the plan at additional cost to themselves.
2. That the AMA investigate and help develop the feasibility of other potential free market solutions to provide patient access including a separate add-on policy for out-of-plan reimbursement for health plans with restricted provider panels, and if deemed feasible, assist the insurance industry in implementation of such products.

Medicare Transformation

The Board of Trustees submitted an informational report that reviewed the background and status of legislative activities related to Medicare transformation, including an AMA action plan for before and after legislation is finalized.

The Reference committee reported that the Board representatives outlined the impressive gains achieved by the AMA to date and emphasized that, those positive items whose continued presence in the budget reconciliation has been threatened still have an excellent chance of passage this year or next. The Board emphasized that a tone of measured optimism was in order on the following items:

- Improvements in the security of traditional Medicare;
- New choices for patients, including medical savings accounts, rather than "forced" managed care;
- Patient protections;
- Elimination of the flawed MVPS physician payment update formula so that, under moderate and reasonable volume assumptions, physicians do not face annual payment rollbacks, as projected under current law;
- Physician sponsored networks and targeted antitrust relief to allow their formation;
- Liability reforms, including a $250,000 cap on non-economic damages;
- A new graduate medical education trust fund;
- Relief from unnecessary CLIA and Stark I and II provisions.

Root Cause of Violence

The Board of Trustees submitted a report that expressed continued strong support for the programmatic efforts of the National Center for Injury Prevention and Control at the centers for Disease Control and Prevention. The Board noted its willingness to work with any group to lessen the effects of violence in our society.

The Reference Committee reported that nearly all those who testified expressed strong support for the Board's efforts to continue the AMA campaign against family violence. The House amended current AMA policy calling on the AMA to support the CDC's efforts to:

a. conduct research
b. develop a national program of surveillance and focused interventions to prevent injuries, and
c. Evaluate the effectiveness of interventions, implementation strategies, and injury prevention programs.

The policy also calls on the AMA to:

1. support a Public Health Service public information campaign to inform the public and its policy makers of the injury problem and the potential for effective intervention;
2. support the development of a National Center for Injury Control at the CDC;
3. encourage state and local medical societies to support, in conjunction with state and local health departments, efforts to make

Continued on next page

Delegate's Report

Continued from previous page

injury control a priority and advise the leadership of the United States Congress of this unqualified support.

Graduate Medical Education Funding

Concern for the future funding of graduate medical education was evidenced by the introduction of six resolutions on this important issue. The Council on Medical Education reported that there was a study already underway with a report expected for the 1996 Interim Meeting. The House adopted a substitute resolution calling on the AMA to undertake a comprehensive study of the options for financing graduate medical education and develop recommendations to provide a stable, rational, adequate, and feasible system for financing graduate medical education, including mechanisms to implement an all-payor system, the use of vouchers, payment for training in non-hospital settings, and appropriate allocation of the training component of the Average Adjusted per Capita Cost(AAPCC).

AMA Budget, Fiscal 1996

The Board of Trustees submitted the AMA's 1996 Plan and Budget showing consolidated operating revenues budgeted at $204.9 million and consolidated operating expenses, including income taxes, at $202.4 million. Budgeted revenues in excess of expenses are $2.5 million.

The House voted to commend the Board of Trustees and the Executive Vice President for their actions in improving the financial position of the AMA and in planning for 1996 and beyond.

Conclusion

Time prevents me from commenting on everything that was considered by the House of Delegates.

Meetings of the AMA House of Delegates are open to every member and are conducted in a most democratic manner. They provide those who attend a unique educational experience as a wealth of information is disseminated and discussed. Members may present testimony at the Reference committee hearings and there are many other opportunities to get your views across.

If you cannot come to the meetings, let your delegation know your opinions and concerns.

Many AMA policies and programs began with an individual physician who had a good idea and coaxed it through the democratic process.

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Doctor Joseph R. Stirlacci

Dr. Joseph R. Stirlacci, 72, a practicing pediatrician for 40 years, died on February 17, 1996 at home after a long illness. He graduated from Classical High School in 1941; Trinity College, Hartford, CT in 1947; and Georgetown Medical School, Washington, D.C. in 1951. He completed his Pediatric Residency at Boston Floating Hospital, Boston, MA.

During World War II he served as a first lieutenant and executive officer in the U.S. Navy. He was awarded the American Theater Ribbon, the Asiatic Pacific Ribbon with two stars, the Victory Ribbon, and a star for the Philippine Liberation.

He was a diplomate of the American Board of Pediatrics, a Member of the American Academy of Pediatrics, the American Medical Association, the Hampden District Medical Society, and the Irish Medical Society. He was a member of UNICO and was honored as its Man of the Year in 1990.

He leaves his wife, the former Grace Ciampi; three daughters, JoAnn Trauschke and Mary Ellen Gallagher of Feeding Hills, Agawam, and Donna Stirlacci of Springfield; two brothers, Frank of Springfield, and Ronald of North Miami, FL; four sisters, Patricia Clark of Springfield, Roseanne Stirlacci of Feeding Hills, Geraldine Stirlacci and Gloria Heywood of Agawam; and five grandchildren.

Joe Stirlacci was best known for his endless energy, a common sense approach to problems, a deep devotion to his profession, and his thirst to improve his diagnostic skills. As a friend he was always available for advice and comradery. He is a great loss and will be impossible to replace.

Memorial contributions may be made to Baystate Medical Center Children's Pediatric Unit, Chestnut Street, Springfield, MA or to Pioneer Valley Girl Scout Camping Fund, 40 Harkness Avenue, East Longmeadow, MA 01028. ■

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AMA President-Elect Defends Association's Endorsement Of Republican Congressional Medicare Plan

Dennis S. Gordan, M.D., Editor

Daniel H. Johnson, Jr., M.D., President-Elect of the American Medical Association, was the featured speaker at the Hampden District's Winter Meeting January 23rd at the Sheraton Springfield. Dr. Johnson, of Metairie, Louisiana, a clinical Professor of Radiology and Otolaryngology at Tulane University, continued the tradition of many presidents-elect. His comments, which drew on his long career in organized medicine, addressed several contentious topics.

The Clinton planners did not consult organized medicine even though the AMA had been proactive in 1986 and thereafter.

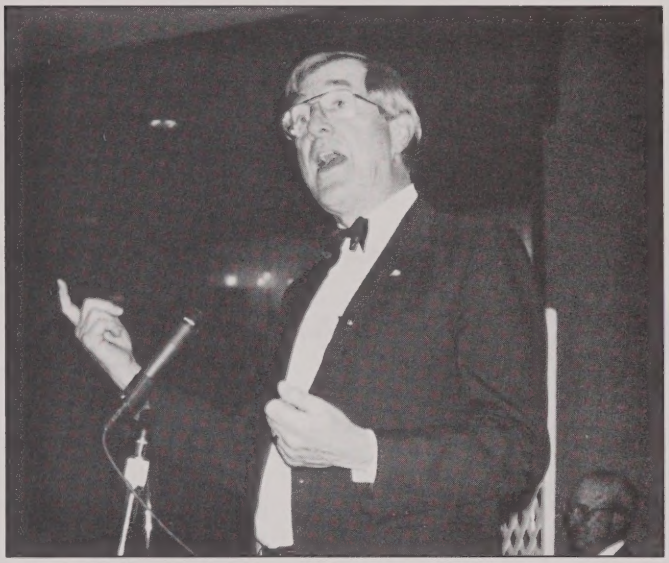
While many physicians have taken issue with the AMA's endorsement of the Republican plan to transform Medicare, Dr. Johnson justified that endorsement by pointing out that the AMA, as far back as 1986, had predicted bankruptcy for that program unless changes were made. It was seen that the ratio of 4 working Americans for each beneficiary would soon worsen with the aging of the Baby Boomers. This, in addition to escalating costs per beneficiary, induced Congressman Charles Rose to introduce bills in several congressional sessions, to revamp Medicare. None of these got anywhere. Later, the Clinton planners did not consult organized medicine even though the AMA had been proactive in 1986 and thereafter. The AMA was purposefully excluded. Dr. Johnson contrasted this behavior with the Republican leadership which in May, 1995, asked the AMA to send representatives to Washington to advise the Commerce and Health subcommittees about what should be done. About 90% of the ideas presented by the AMA at one two-hour and twenty minute meeting were adopted by the House, and most survived the subsequent conference committee. With such a positive outcome, the AMA endorsed this plan into which it had such input.

Dr. Johnson felt that although Democratic reductions have been touted as necessary to save Medicare, the Republican reduction had been branded as destructive. He pointed out that the Democratic plan provided funding at 95% of the current projected levels, while the Republicans' kept it at 92%. He felt that, in view of the incorporation of most of the AMA's recommendations, the 3% difference was a small price to pay.

Dr. Johnson also felt that these differences in funding levels were secondary in comparison to the differences in philosophy between the Administration and the Congressional plans. He noted that price controls and reduced choices have not worked and that the real problem has been the insulation of consumers from the costs of services by all types of insurance. The remedy–linking patients to costs–is better achieved through the Republican proposal to offer options to Medicare patients. If they make cost effective choices, they should reap the rewards whether they choose HMO's, PPO's, MSA's, or any other form of insurance. Further, he pointed out in the question and answer session, that MSA's (Medical Savings Accounts) are presently discriminated against by the Federal government, but a change in the laws could level the playing field. In MSA's, careful use would reward the patient, not the HMO, when fewer and/or less expensive services were used. In addition, MSA's demonstrate back-end loading, that is there is first dollar coverage, but usage is charged at the end of the insured period through the reduction of a cash or other payback.

Additionally, Dr. Johnson pointed out that:

1. Tort reform, although it may reduce premiums, will thus only cut costs by a fraction of the 1% of medical costs that are represented by malpractice insurance, at best, while it has been demonstrated to do nothing to reduce the costs of defensive medicine, and these represent 4 to 5% of medical costs. It is thus not a make or break issue.
2. More money is expended on the defense bar than the plaintiffs' bar in malpractice cases.
3. The major outcome of the Federation's study to redo organized medicine will hopefully be a reduction in the duplication of effort put out by specialty societies and local, state and American medical societies.
4. Although physicians may feel that alliance with disparate HMO's, hospitals, etc., may militate against collegiality among physicians, reliance on our fiduciary responsibility to do the right thing for our patients, at the right time, should continue to unite us. ■



Daniel H. Johnson, Jr., M.D. President-Elect of the American Medical Association was the featured speaker at the Hampden District's Winter Meeting on January 23, 1996

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Medicare $ + Medicaid $ + Private $ ÷ 5 = Corruption

by Dennis S. Gordan, M.D.

Physicians' alarm at the changes taking place in the structures and financing of medical care raises little sympathy in the general public, who see our efforts to modify those changes as mainly self-serving. But it is not only physicians and others working in medical fields, along with the poor, the sick, and the disabled, who stand to lose. Every citizen is having a part of his or her soul sold to a growing commercial element by a Congress willing to sacrifice our freedom on the altar of market forces. Whether Americans in general think their health care will be affected adversely or not, it is in everyone's interest to prevent the concentration of economic power that is occurring.

Every citizen is having a part of his or her soul sold to a growing commercial element by a Congress willing to sacrifice our freedom on the altar of market forces.

Even conservative estimates of the dollars and the consequent political clout being handed to faceless insurance executives are frightening. If healthcare spending remains at about 14% of Gross National Product (equivalent to greater than half of the Federal budget), continuation of the present merger and buyout trend will soon have a few (the Big 5?) insurers each collecting more in premiums than any state collects in taxes, more even than the gross domestic product of many states or nations.

There has been no precedent for such a government-directed flow of wealth from so many to so few. If Medicare and Medicaid beneficiaries are pushed into private managed care, dollars that now travel from citizen to U.S. government through relatively inexpensive intermediaries to providers may soon go from citizens to government to expensive (how is a 25% cut?) insurers to impoverished providers, on top of dollars that insurers already collect from their private customers. Americans will look back with nostalgia at the $20 million a year given to the CEO of U.S. Healthcare as an example of merely egregious greed compared to what the Big 5 execs will take. Might we expect those who facilitated such a monumental transfer of wealth to be able to refuse the gratitude of the chosen few?

The potential for corruption at the top, however, is matched in scope, if not in strength, by the potential at the bottom. All that money could have great influence on local bosses deciding who will ensure their company, town, county, or state employees.

In the face of the above, those little details about quality of care, access, patients voting with their feet, etc., mean little. Bricks and mortar industries, even hospitals, have reputations and names to preserve and enhance, local community support to encourage, and contributions to make. What do present MCO's, or any of the acronyms into which they are likely to metamorphose, once their true natures are exposed, have to compare? Their only equity is likely to be their computer program–the office and computer are rented. Location matters not a whit when electronic fund transfer is their only interaction with the outside world. Even the railroad robber barons usually built something useful and were related to their geography. Health insurance robber barons are quite the opposite, deconstructing as much of the medical enterprise as they can get away with. It appears that they consider no one as friend or constituent, except self and stockholder, nothing as valuable, except the dollar. They have gone from "Zero defects" as a motto, to "Zero conscience." What have they done to prove that we should trust them?

Let us not create a corrupting autonomous focus of power. If local government entities are going to finance and plan for local needs, they should not have to do it with corporation as large as even present-day conglomerates. We should stop the mergers and break up national insurers as we broke up Ma Bell. Let the law catch up with the newly possible abuses before we go on. If that can't be done, perhaps a moratorium on mergers involving companies representing more than $15 billion in premiums would help. Those that are already bigger could be given the Ma Bell treatment - even Republicans should agree that the resulting regional companies could better handle local concerns.

Another tactic might be truth in advertising. More useful than commercial statements about "all the care you need," and "best," which are impossible to interpret, might be simple numbers much like the nutritional and mileage data we now see on foods and new car stickers respectively:

ABC MCO	$	%	Average for participant	Range for insurers of this size
Total premium per year	10 billion	100	6000	8-12 billion
Amount spent on medical care (i.e. loss ratio)	7 billion	70	4,2001	6-9 billion
Amount distributed to Shareholders	2 billion	20	12000	1-2 billion
Amount given to top Executives in:				
pay	100 million	1	60	50-100 million
stock option	200 million	2	120	150-220 million
benefits	300 million	3	180	250-350 million
all others	100 million	1	60	50-100 million
Total Value of Denied Services in Dollars: 1 billion				

The employer mandate could be modified to a requirement for a certain amount of health insurance support, not selection. The employees could direct this money to the insurers of their choice. Armed with the above statistics, they could decide to buy a policy that might require some copayment of premiums, but would result in more useful service.

Finally, we could scrap it all and go to single payer. In any event, the chaos that now pervades medicine is doing no one any good except the insurers. Physicians and the public need to demand that we get out of the stampede mode where all the long term effects are ignored, and into one in which reason takes hold. ■

In Memoriam

Dr. I. Daniel Hosman, 87 of Chicopee a retired 62-year physician, who worked with the Chicopee schools and was a former commander of Guantanamo Bay in Cuba, died February 11 at Baystate Medical Center.

Born in Chelsea, he lived in this area since 1935. He had been in private practice and was the consulting dermatologist at the Holyoke Soldier's Home.

He retired as the physician for the Chicopee Public School system in 1995 after many years of service.

He graduated in 1929 from Harvard University, where he received his Bachelor of Arts degree and in 1933 he received his medical degree from Chicago Medical School. He did post-graduate work at Boston City Hospital in Boston and at Bellevue Hospital in New York City.

A physician and surgeon in the Army during World War II, he attended Military Medical School in Carlisle, Pennsylvania. He was the Commanding Officer at the Army Air Base at Guantanamo Bay.

He was a member of the American Medical Association; the Hampden District Medical Society and the Director of Edward Belhamey Memorial Association.

He also was a member of the Wilbraham Tennis Club.

He leaves his wife the former, Molly Jankowski; a son, Todd of Estes Park, CO; a daughter, Patricia Hans of Rochester, NY; two sisters, Kate Edwards and Beverly Sherman both of Boston. ■

MMS Addresses State John Hancock Hassle Factors

In response to the numerous complaints recently received from members, including members of the Hampden District, MMS staff met with senior management of the State John Hancock Plan (SJH) on February 2, 1996. The problems which had been identified were brought directly to the attention of Senior Administrators Felix Conti and Jim Valente and the Associate Medical Director Dick Chaset, M.D. Physicians' names remained confidential. The following items were discussed.

SURGICAL PROCEDURES AND LEVEL V OFFICE VISITS (99215)

Physicians have been experiencing significant payment delays for surgical procedures and level V office visits (99215). Upon receipt of surgical claims the SJH Claims Review Unit will request operative notes and pathology reports to determine if the appropriate CPT code was reported (make extra copy of medical record for potential appeal process. See below.) SJH may downcode a procedure to a CPT code which reflects a service of lower complexity. As a result, reimbursement will also be subject to a reduction

Physicians and their staff must monitor the EOBs from SJH to ensure that procedures are not incorrectly downcoded. If a CPT was changed by SJH and the new code does not reflect the service provided, an appeal should be submitted.

CLAIMS CHECK-CLAIMS PROCESSING SOFTWARE

The State John Hancock Plan installed and implemented a claims processing software program which is used to identify and review claims submitted with multiple CPT codes. The software, Claims Check, will bundle services into

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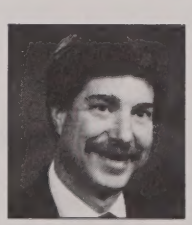
- malpractice claims due to inadequate informed consent?
- reducing estate taxes, and protecting assets from creditors' claims?
- providing for the orderly disposition of your practice in the event of death or disability?



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Arthur W. Price and Michele J. Feinstein, partners in Cohen, Rosenthal, Price, Mirkin & Wernick, have more than twenty-five years of combined experience in representing area physicians in their practices and individually. They counsel solo and group practices in their day to day businesses as well as in their planning for growth or extraordinary concerns. They also advise physicians on personal and family problems.

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one CPT code, which it has determined, reflects all of the services provided and remit payment accordingly.

Similar software programs are becoming commonplace in managed care plans. Physicians must take action in monitoring their payments and submitting appeals if the CPT codes are bundled incorrectly.

Appeals should be directed to:
Claims Review Unit
P.O. Box 9018
300 Brickstone Plaza
Andover, MA 01810
or fax to: CRU - (508)474-5174

MEDICARE CROSSOVER CLAIMS

The processing of Medicare crossover claims is estimated to take no longer than twelve weeks from the date the claim was submitted to Medicare. The crossover claims are compiled monthly at Medicare then forwarded to SJH during the second week of the following month and subsequently processed through the SJH claims system. SJH Customer Service should be contacted if claims are not processed within twelve weeks. MMS will continue to monitor this issue.

NEW PRODUCT-STATE JOHN HANCOCK PLUS

The State John Hancock Plus Plan is a new product which will be offered to active state employees and non-Medicare state employees during the April 1996 open enrollment period for an effective date of July 1996. The Plus Plan includes a listing of "Select Providers" made up of 38 hospitals and 7500 physicians statewide. Subscribers will have the choice of receiving services from any physician however, they will receive maximum benefits if they choose a "Select Provider". The Plus Plan does not require the use of a gatekeeper (PCP) or referrals and physicians will be reimbursed according to a fee schedule rather than the 90th percentile of reasonable and customary charges. Of note, some of these SJH contracts obligate the physician to submit all medical records for any and all procedures in order to determine medical necessity. This appears to be a broad provision. Clarification will be helpful. ■

Yael Miller, Director
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Gun Control

Although it is said that everybody loves a Saturday night, the same is not true of Saturday Night Specials. In the face of information about these guns and the Medical Society's campaigns against domestic and other violence, a grassroots effort to stem the flood of available firearms is indicated. The Congress' lack of will in this area makes it even more important. Fortunately local efforts can be effective.

If information from Physicians for Social Responsibility (PSR) is correct, there should be about 500 licensed gun dealers in the Pioneer Valley. Most are not in the Yellow Pages since they operate out of their homes, perhaps in your neighborhood. Although most guns used in crimes were originally purchased legally, legal transactions also include resales of guns by legal owners who are simply not licensed gun dealers and are thus beyond federal control. There are only 200 federal agents available to monitor the 200,000 (sic) licensed gun dealers in the nation. They need help. Local police can give them that help if local ordinances are passed that, for example:

1. Simply ban the sale of Saturday night specials.
2. Require gun dealers with or without Federal Firearms Licenses to get a permit from the local police.
3. Prohibit gun dealing from private residences, flea markets, and /or
4. Require gun dealers to obey the same regulations (zoning, hours of operation, etc.) as other retailers.
5. Require insurance, background checks, security measures for dealers.
6. Impose a tax on all transactions, new and resale.

If nothing else, at least some prospective new dealers won't set up shop, and the police will know where the legal sources are. Those legal sources, remember, are the origins of most guns used in crimes. At best, gun selling could be kept farther from our homes, and with it, the violence it brings. ■

Dennis S. Gordan, M.D.

In Memoriam

Dr. John C. Tate of Birch Hill Road in Agawam died on December 11, 1995, at the Holyoke's Soldier's Home, at age 87. He had been a senior surgical staff member at Springfield Hospital and had received a 50-Year pin. He also had been on the staff at the Soldier's Home and had worked in Fairfield, Maine, as well as at the former Westfield Sanatorium.

Dr. Tate had been born in Mechanicsburg, PA, and attended the former Southwestern University (now Rhodes College) in Memphis, TN. He graduated from the University of Tennessee Medical Center and interned at Memphis General Hospital.

He served as a lieutenant colonel in the Medical Corps of the Army Air Forces during World War II, specializing in thoracic and general surgery.

After moving here, Dr. Tate worshiped at Christ Church Cathedral and became a trustee of the Agawam Center Library Association.

Besides belonging to the American Medical Association and the Massachusetts and Hampden District Medical Societies, Dr. Tate was a fellow of the American College of Surgeons.

He leaves his wife, the former Margaret Tompkins; a daughter, Ann T. Hall, of Agawam; five grandchildren ; and nine great-grandchildren. His son, Charles L., had died in 1980.

Dr. Tate was buried at Hillcrest Park Cemetery in Springfield.

Memorial contributions may be directed to the Open Pantry, 755 Worthington St., Springfield 01109, or the Rescue Mission, Inc., 19 Bliss St., Springfield, MA 01105. ■

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Hampden Committee Activities

The **Public Health Committee** met in November and December. Dr. Barnshaw had written an article on the Single Payor System. The committee members discussed the single payor system with opinions both pro and con. They felt that Dr. Barnshaw should send his article to the Hampden Hippocrat as a Letter to the Editor type response to Dr. Papale's President's Page in the Fall issue of the Hippocrat. Please take the time to read it. The committee was hoping the article would generate further dialogue on the single payor system.

The Public Health Committee also discussed the proposed needle exchange program in the city of Springfield. Drs. Riley and Sheffield attended meetings concerning the program. They both support the needle exchange concept proposed by the Mass. Dept. of Public Health. The primary benefit of the program has been to clean up needles being used by IV drug users. IV drug users do drugs in groups and pass needles around. The program also helps to identify drug users and get them into treatment. The committee decided that a letter should be sent to Mayor Albano supporting the needle exchange program.

The **Executive Committee** met in October and November. Discussion at the October meeting centered on the Hampden Hippocrat. Ms. Barnes, business manager for the magazine, presented committee members with suggestions for improving the magazine. The committee felt that there should be at least four co-editors. Since the magazine has gone to four issues a year, this would give the responsibility of only one issue a year to each co-editor. The committee also felt that the magazine must have 28 pages, with 50% of the space devoted to advertising. Suggestion was also made to expand on our mailing list.

Dr. Glackin, one of the co-editors of the Hippocrat, gave a background report on the Hippocrat during the years she has been editing the magazine. Also, Dr. Glackin agreed to stay on as an editor for one issue per year. In addition to Dr. Glackin, Drs. Dennis Gordan, Francis Horrigan and John Papale have all agreed to be an editor for one issue of the Hippocrat per year.

The November meeting was devoted to reviewing the 1996-1997 budget and further discussion concerning the Hippocrat. The budget was approved by the committee members and will be presented to the members for their approval at the January 23rd District Meeting. ■

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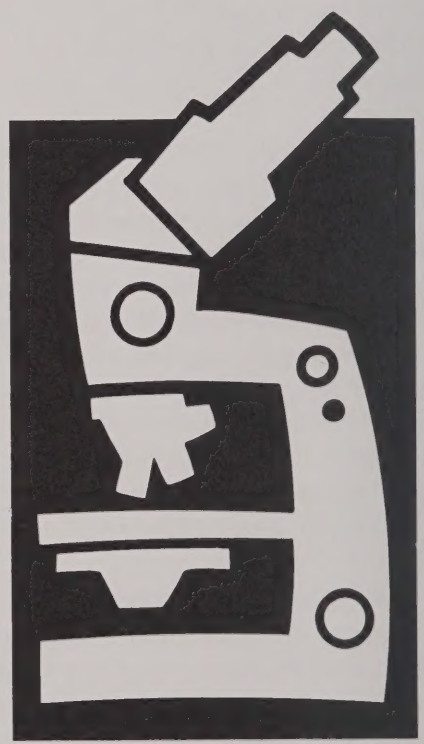

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Letter To The Editor

In response to Dr. Papale's President's Message "Are We Ready for Single Payer?" fall '95

H.D. Barnshaw, M.D.

The main mission of the Single Payer System is to provide universal medical coverage that is portable, accessible and affordable.

Currently we have up to 40 million uninsured at any one time, and 64 million underinsured. Obviously to cover everyone would increase costs. The Congressional General Accounting Office estimated that a Single Payer System would have 10% administrative costs saving 100 billion dollars from our current system which would pay for this increased coverage. It not only would make our billing simpler and save physician's administrative costs, doctors could make long term commitments to their patients and not be concerned that the insurance plan might change and the patient would have to see a different physician. Increasingly patients in our current system do **not** have choice over which doctor or which hospital to use. A Single Payer System could give that choice back.

In the current system more and more the emphasis is on the "bottom line" for the current fiscal year. Managed care and HMO's reward giving less care, and sometimes deny care.[1] In a Single Payer System we are all in it for the long run, and the emphasis will be on the best care for the life of the patient. The emphasis shifts to collaboration and the public's health, not competition and profit.

Dr. Papale questions the cost efficiency of Single Payer System and gives as illustrations a number of governmental services. But all of these are in areas other than health. The example to look at is Medicare, the largest Single Payer System in the world. Here the administrative expenses are 2%, way below what the private sector does. Medicare is under debate now and deserves an article in itself.[2] Here are a few points to consider. Medicare Select, which allows seniors to select private insurers in 15 states, cost more than standard Medicare in 7 of those states. Over all Medicare's per capita costs have grown only 0.3% faster than private insurer's in '93 in spite of covering the oldest and sickest segment of our population. We know that this population will grow. The fairest way to fund these costs is to create a bigger risk pool i.e. the Single Payer System.

Quality of care is something that everyone says, but how to measure and monitor? Basically it comes back to professionals in the system doing the review. Wouldn't you trust quality review coming out of a public health orientation more than out of a for profit organization? In a Single Payer System there could be competition for patients, as patients could have choice of which doctor to see, and what hospital to enter. Over time patients will chose quality.

All this isn't to say that a Single Payer System wouldn't have its problems. How well it would work would depend on the "details" of how it is set up. What would be the relationship to the government; how would it be funded in years when the economy is down? What would be the process of deciding what would be covered, and what the payment would be? How would the physicians organize to negotiate with the health organization making those decisions etc, etc. (See article on Dr. Kuzmarov's presentation "The Current Status of the Canadian Health Care System..." in the Hippocrat Nov. 1994.) There would be a public debate on these issues.

So the question becomes which Single Payer System would best fit our values and needs. It would have major differences with the Canadian system. For example, we are already spending a larger % of our GNP on health care than Canada, and this is unlikely to go down. What we need to do is to prevent further increases and there is evidence that a Single Payer System could do that plus cover everyone. Lets set up a system that encourages physicians to be physicians, to care for patients and not to be coerced by the "bottom line."

(H.D. Barnshaw, MD is a member of the Public Health Committee which encourages physicians to write in their thoughts about the evolution of our Health Care System the number one Public Health issue according to the Harvard School of Public Health.) ■

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MMS Executive Briefs

AG Seeks Info About Network Solicitations

At the Society's request, the Office of the Massachusetts Attorney General is seeking information about physician network solicitations across the state. Certain managed care brokerage firms that advertise national physician networks have been very active in Massachusetts in recent years, and the Society has cautioned physicians to obtain sufficient information before making financial commitments to such brokerage firms. Firms that have been most active in Massachusetts are Healthcare Networks of America, Inc. (HNA), Allied Group Network, Inc. (AllNet), and Health Designs, Inc. Physicians have reported aggressive sales tactics and difficulty obtaining information and refunds from some brokerage firms.

The Attorney General's office is seeking specific information from physicians who have dealt with HNA, AllNet and/or Health Designs. Physicians who can assist in the AG's inquiry can call the AG's office at (617) 727-2200 (ask for attorney Pasqua Scibelli) or the Department of Legal Services at MMS headquarters (extension 1316). It is particularly important for physicians who have lost money or had other difficulties with these organizations to inform the Office of the Attorney General as soon as possible.

Internet Services Now Available To MMS Members

MMS members who wish to take advantage of the information and communication applications of the Internet can now sign up for the Society's new member service – *MassMedNET*, the Internet Service of the Massachusetts Medical Society. The MMS Internet service, unveiled at last month's Interim Meeting of the MMS House of Delegates and available ONLY to MMS members, provides physicians with access to electronic mail, newsgroups, and the World Wide Web (WWW), including the Medical Society's site on the WWW. Members who complete and

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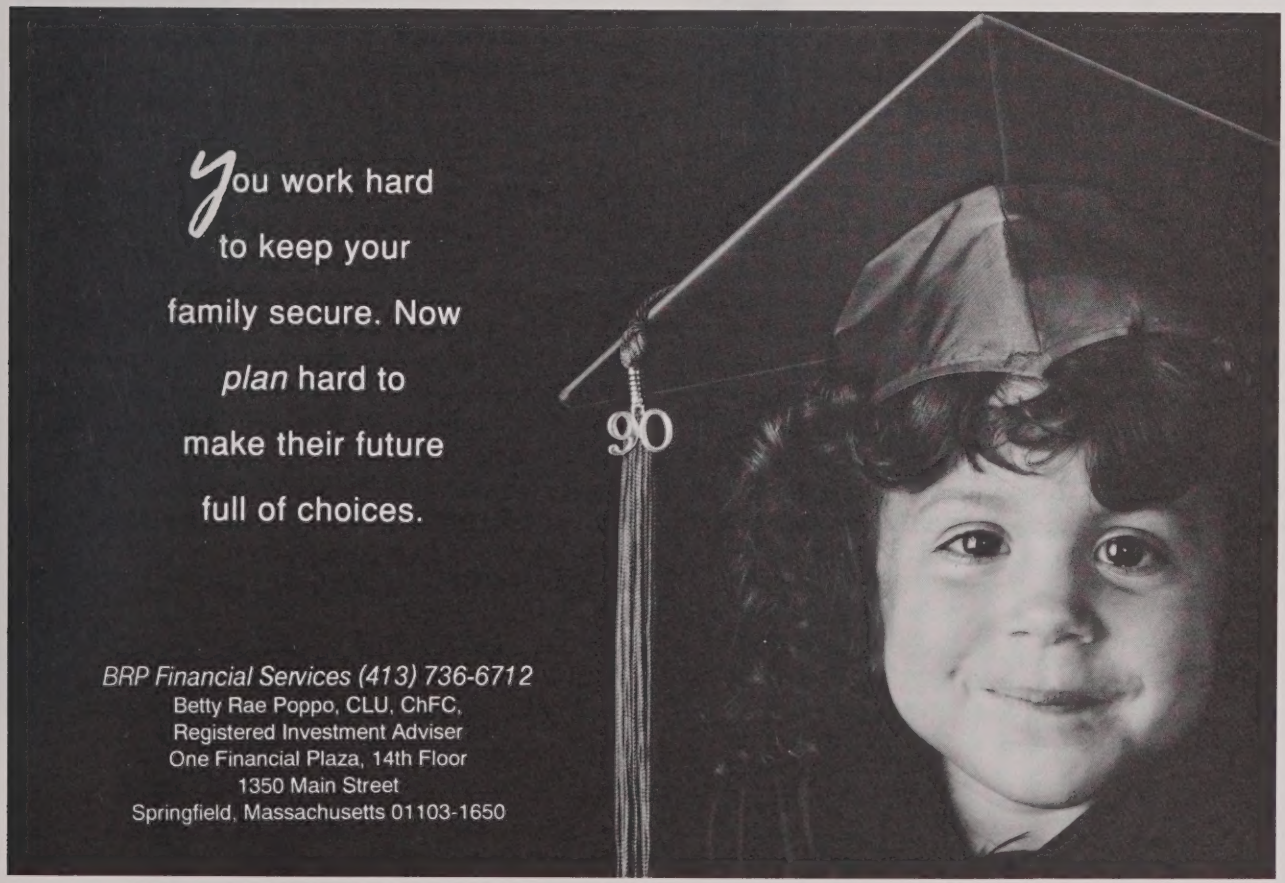

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return a MassMedNET application will receive a verification of their account information, a members' handbook, and technical assistance, which includes minimum computer specifications and step-by-step setup instructions on how to set up various Internet software packages. For a MassMedNET application kit, contact the Department of Membership Services (extension 1370) at MMS headquarters; or send an e-mail request to ***signup@massmed.org***.

Report: Cut Medical School Slots by 2000

A major report released in November by the Pew Health Professions Commission called for *one in every five U.S. medical and nursing schools to be closed by the year 2000* to cut a surplus of the nation's physicians and nurses. The report, expected to further ignite the national debate on physician supply, also recommended a sharp curtailment of the number of international medical graduates entering the United States. Commission members include representatives from health insurers, physician, nursing, and other health professional groups, teaching hospitals, and academia.

Profiling Bill Clears House

The *physician profiling bill* was approved by the Massachusetts House of Representatives on November 15, the last day of the formal 1995 legislative session. The profiling bill, which would provide more information to the public about physicians practicing in Massachusetts, was the Medical Society's top legislative priority this session. The bill now heads to the state Senate, where it may see action before the end of this year. "We're delighted that the House was able to pass the physician profiling bill," said MMS President Dr. Guenter L. Spanknebel, "and we look forward to the speedy passage of the bill by the Senate." Dr. Spanknebel also commended the leadership of House Speaker Charles Flaherty and Joint Health Care committee Co-Chair John McDonough "to move this bill through the legislative process."

MMS Voices Concern About Gambling Bills

In testimony before the Joint Committee on Government regulations in November, the MMS voiced concern about three bills that *would expand gambling in Massachusetts.* The bills would create casinos in New Bedford and western Massachusetts, and permit slot machines at race tracks. There are approximately 300,000 problem gamblers in Massachusetts, the Society testified, and the problems associated with this disorder – loss of jobs and family, crime, depression, and suicide – are well documented. Government sponsorship and marketing of legalized gambling is a major contributor to these problems, the MMS noted, and "government has a unique moral responsibility to fund treatment for them."

New Anorectic Regs In Progress

The Board of Registration in Medicine voted last week to rescind its current regulations that prohibit the *prescribing of all medications for their anorectic effect.* The Board, however, maintained the ban for prescribing of Schedule II drugs for appetite suppression.

First-In-Nation Ban On Gag Clauses Signed

The first-ever law to ban the use of "gag clauses" in managed care contracts for physicians was signed. The ban, part of House 5347, the patient confidentiality bill, was signed into law by Massachusetts Governor William Weld on January 19. The new law, which takes effect 90 days after signature, also protects the confidentiality of mental health information. "Massachusetts physicians will no longer need to fear retaliation from commercial insurers' and managed care plans for fulfilling their duty as patient advocates," said Guenter L. Spanknebel, M.D., MMS president, as the bill was signed. These contract clauses "were a true violation of the physician-patient relationship," he said, and "interfered with physicians legal and ethical duty to act in the best interest of their patients."

A *Boston Globe* story on January 23, "New law

bans gag rules on doctors," described the effects of such physician contract clauses on patient care. MMS Government Relations Directory Michael Kelly, in the story, rebutted insurers' claims that contract clauses "do not gag" physicians. The American Medical Association (AMA) applauded the new law and called on health plans nationally to "immediately cancel "gag" clauses in their contracts or policies with physicians.

Emergency Regs For "Drive-Through Deliveries" Approved

On January 23, at its monthly meeting, the Massachusetts Public Health Council approved emergency regulations to implement Chapter 218 of the Acts of 1995, commonly known as the *drive-through delivery* law, which went into effect on February 19, 1996. The legislation sets minimum benefit levels for insurers and requires hospitals to provide minimum lengths of stay or home-based services for all maternity patients. The emergency regulations define early discharges as those occurring within 48 hours of vaginal birth or 96 hours of a Cesarean delivery; require agreement between a mother and her physician prior to early discharges; prohibit involuntary discharges of maternity patients between the hours of 6:00 p.m. and 9:00 a.m.; and require hospitals to establish protocols, consistent with the standards of the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, for early discharge services.

The emergency regulations also require that all new mothers receiving an early discharge be provided, if they agree, at least one home visit by a physician, registered nurse or certified nurse midwife trained in maternal and infant care; and require that hospitals write individualized early discharge plans and provide notice to each maternity patient of their rights under Chapter 218 at admission and in pre-registration materials.

Hearings on permanent regulations will be held in March. For more information, contact the Department of Government Relations (William Ryder, J.D. at ext (1330) at MMS headquarters.

MMS Testifies Against Bill To Reorganize State Government

The MMS testified in early February against a bill (House 5804) that would *effectively eliminate an independent Massachusetts Department of Public Health.* The bill, part of Governor Weld's plan to reorganize state government, would transfer current Mass. DPH functions to a new Division of Family Services; this new Division would include Medicaid and several other state agencies and programs which oversee the delivery of health care. Jack Evjy, M.D. delivered the Society's testimony at a February 7 hearing before the Joint Committee on Health Care.

The Society termed the bill "a threat to the efficiency, autonomy, and perhaps the very existence" of the Massachusetts DPH, noting that the department's responsibilities "are not limited to the service of families, the health needs of the poor and disabled, or the oversight and funding of institutional health care, as House Bill 5804 implies." Dr. Evjy described his personal experience working with Mass. DPH on creation of protocols for bone marrow transplantation, stressing that by bringing together patients, physicians, insurers, and other interested parties, the department successfully developed a system that was fair to insurers, provided valid outcome data, and helped cancer patients make informed choices on their care. He also warned that an independent Commissioner of Public Health was "essential" to dealing with public health emergencies.

National Managed Care Survey Released

Hospitals with high use of managed care plans seem to have smaller death rates as well as lower costs and shorter hospital stays, it was revealed in a *national managed care survey*. The national consulting firm KPMG Peat Marwick, in surveying 1,400 hospitals in the largest American cities in 1994, found that hospitals in Northern California have an average cost per visit of $2,970,

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almost half the national average of $5,500. The California hospitals are located in areas of the country with some of the highest percentage of enrollees in health maintenance organizations. The study cautioned, however, that cost savings are beginning to flatten out for managed care plans, particularly in highly competitive markets.

Child Insurance Plan Accepting Applicants

The *Children's Medical Security Plan* (CMSP) is now accepting applications for immediate enrollment of qualified children. The plan, developed by the Department of Medical Security, provides both primary and preventive care benefits for children from birth through age 12 who reside in Massachusetts. The plan offers coverage to children who meet age/residency requirements and are uninsured, underinsured, or not eligible for Medicaid coverage. For information on the plan or to obtain applications for coverage, physicians should contact the CMSP Customer Service Department at 1 (800) 909-2677. ■

New England Journal Editor Addresses Maimonides Club

Dr. Jerome Kassirer, editor of the New England Journal of Medicine, addressed a gathering of 103 individuals at the December 6, 1995, meeting of the Maimonides Medical Club at the Delaney House. His lecture, "The Imperiled Physician," touched on many of the themes about which he has written in the Journal. He was able to give considerable time to audience questions after his prepared comments.

Among his concerns was the fact that one of the basic premises of healthcare reform, namely that this country cannot afford to provide universal coverage except through managed care, has never been demonstrated. Most authorities accept this premise, however, and are, on that basis, hastening to put into place an untested system which is touted as both more cost effective and more interested in quality outcomes. Although he acknowledged that some improvements have come from managed care, he felt the system was unlikely to be beneficial so long as the managers were corporate types, most interested in satisfying shareholders, rather than physicians who maintained patient advocacy and quality care as primary objectives. If the disinterest managed care has shown in education and research continues, the future of medicine is being sacrificed, again without proof that it must be, in order to provide universal coverage. ■

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260 New Ludlow Road
Chicopee, MA 01020

Born: December 13, 1956
Premed: Kinnaird College for Women, Pakistan 1972-1974
Medical: Rawalpindi Medical College, Pakistan 1981
Internship: Meharry Medical College, Tennessee 1988-1989
Residency: Methodist Hospital, Brooklyn, NY 1989-1991
Fellowship: Baystate Medical Center 1991-1995
Specialty: Internal Medicine/Hematology/Oncology

Nayyer Ghias, M.D.
260 New Ludlow Road
Chicopee, MA 01020

Born: July 25, 1964
Premed: Khatoon-E-Pakistan College, Pakistan 1980-1982
Medical: Sind Medical College, Pakistan 1982-1988
Internship: Berkshire Medical Center, Pittsfield 1991-1992
Residence: Berkshire Medical Center, Pittsfield 1992-1994
Specialty: Internal Medicine

Charlotte A. Harward, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: July 13, 1957
Premed: Emory University, GA 1975-1979
Medical: University of Maryland School of Medic ine 1991-1995
Internship: Baystate Medical Center 1995-Present
Specialty: Internal Medicine/Pediatrics
Intern

Kirti R. Kodali, M.D.
305 Bicentennial Highway
Springfield, MA 01118

Born: September 30, 1951
Medical: Medical college Jabalpor MP India 1968-1973
Internship: Baltimore City Hospital 1977-1979
Residency: Baltimore City Hospital 1979-1981 (Francis Scott Key Medical Center)
Specialty: Pediatrics

Shameema Faruqi, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: August 11, 1954
Premed: St. Francis College, India 1970-1971
Medical: Gandhi Medical College, India 1972-1977
Internship: University of Medicine and Dentistry, NJ 1990-1991
Residency: University of Medicine and Dentistry, NJ Dept. of Anesthesiology 1991-1994
Fellowship: University of Medicine and Dentistry, NJ 1994-1995 Pain Management
Specialty: Anesthesiology/Chronic Pain Management

Khaled A. Instrum, M.D.
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Holyoke, MA 01040

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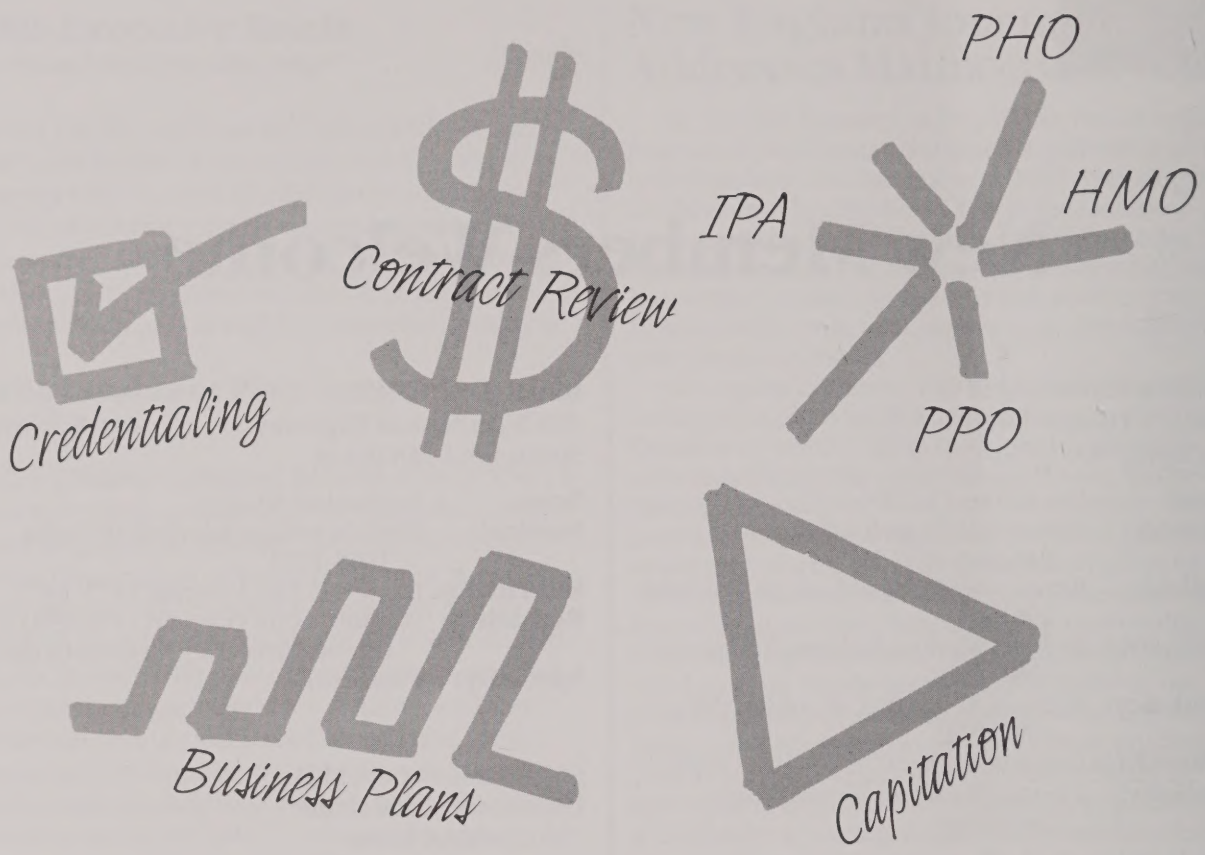
Premed: Dalhousie University, Nova Scotia 1978-1981
Medical: Dalhousie Medical School, Nova Scotia 1981-1985
Internship: Dalhousie University 1985-1986
Residency: University of Calgary, Alberta, Canada 1989-1993
Fellowship: University of Calgary 1993-1994
Specialty: Orthopedic Surgery/Shoulder & Knee



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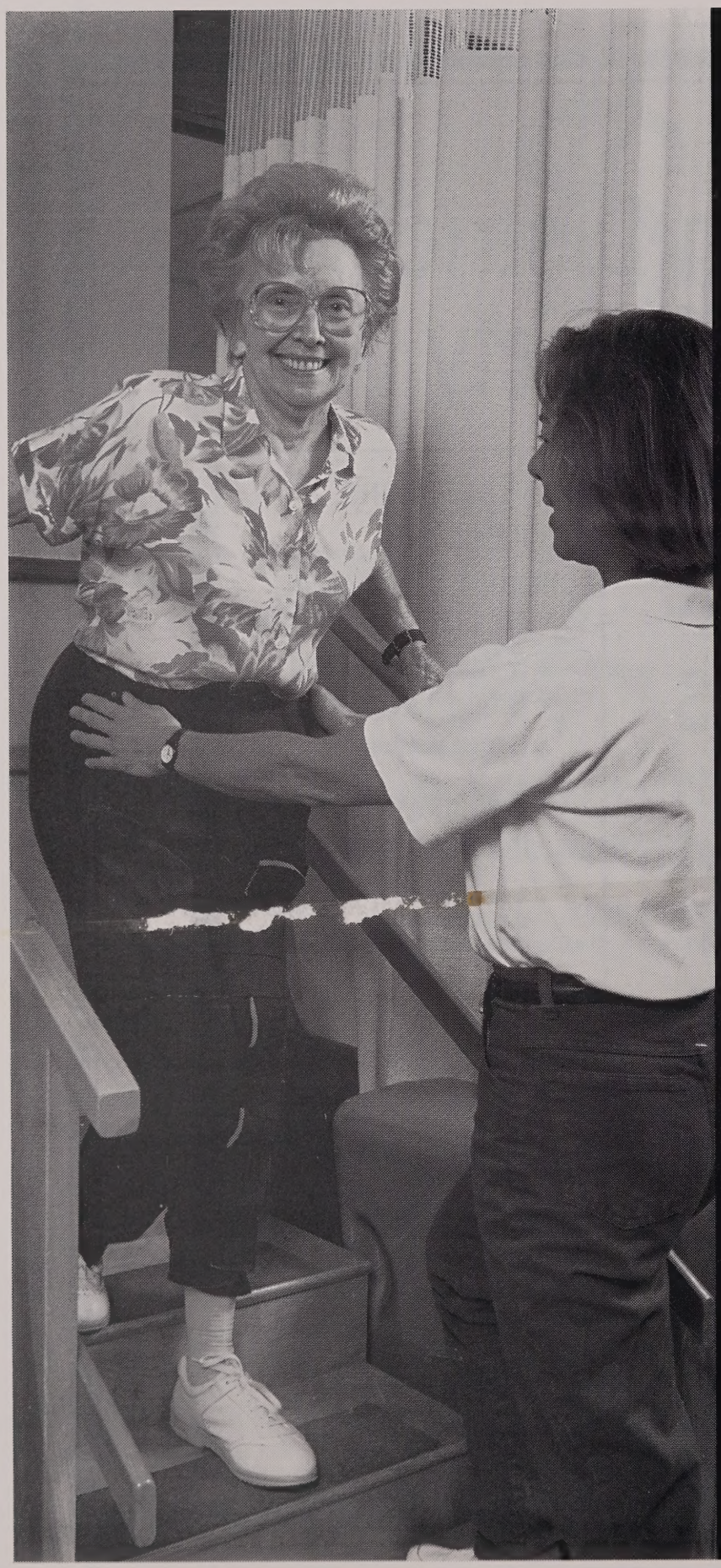

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